BlueCross® BlueShield®

PPO℠ Options v.4

Summary of Benefits

Town of Reading

MIIA MASSACHUSETTS BASED MEMBER DRIVEN

This health plan includes a tiered provider network called Preferred Blue PPO Options v.4. Members in this plan pay different levels of cost share (copayments, coinsurance, and/or deductibles) depending on the benefits tier of the provider furnishing the services. A provider's benefits tier may change. Overall changes to the benefits tiers of providers will happen no more than once each calendar year. For help in finding the benefits tier of a provider, visit the online provider search tool at **www.bluecrossma.com/findadoctor** and search for Preferred Blue PPO Options v.4.

✔ This plan meets Minimum Creditable Coverage Standards for Massachusetts residents that went into effect as of January 1, 2014, as part of the Massachusetts Health Care Reform Law.

Your Choice

PPO Options v.4 is a preferred provider organization (PPO) health plan. You have the option of selecting providers who are part of the network (preferred providers) or providers who are outside the network (non-preferred providers). You'll generally receive a higher level of benefits—and pay lower out-of-pocket costs—when you choose in-network providers.

Your Deductibles.

For some covered services, you must meet a plan-year deductible before benefits are provided. If you are not sure when your plan year begins, contact Blue Cross Blue Shield.

Your deductibles are:

In-Network: $0

Out-of-Network: $2,000 per member (or **$4,000** per family)

The following services are not subject to the deductible: all in-network covered services and emergency room visits.

When You Choose Preferred Providers.

Within the network, certain preferred primary care providers and preferred general hospitals are ranked into three benefits tiers based on cost and nationally accepted quality performance criteria selected by Blue Cross Blue Shield of Massachusetts.

Where you receive care will determine your out-of-pocket costs for most services under the plan. By choosing Enhanced Benefits Tier preferred providers each time you get care, you can generally lower your out-of-pocket costs.

- **Enhanced Benefits Tier**—Includes preferred providers in Massachusetts that meet the standards for quality and are low cost relative to our benchmark. You pay the lowest out-of-pocket costs when you choose providers in the Enhanced Benefits Tier.
- **Standard Benefits Tier**—Includes preferred providers in Massachusetts that meet the standards for quality and moderate cost relative to our benchmark and preferred hospitals that do not meet the standards for quality but are low or moderate cost relative to our benchmark. You pay mid-level out-of-pocket costs when you choose providers in the Standard Benefits Tier. Also includes providers without sufficient data for measurement on one or both benchmarks. To ensure members have provider access in certain geographic areas, the Standard Benefits Tier includes some providers whose scores would otherwise put them in the Basic Benefits Tier.
- **Basic Benefits Tier**—Includes preferred hospitals in Massachusetts that are high cost relative to our benchmark. Also includes preferred primary care providers in Massachusetts that did not meet the standards for quality and/or are high cost relative to our benchmark. You pay the highest out-of-pocket costs when you choose providers in the Basic Benefits Tier.

Note: PCPs were measured based on their HMO patients as part of their provider group, and hospitals were measured based on their individual facility performance. Provider groups can be composed of an individual provider, or a number of providers who practice together. Tier placement is based on cost and quality benchmarks where measurable data is available. Preferred providers without sufficient data for cost and quality are placed in the Standard Benefits Tier. Preferred primary care providers that do not meet benchmarks for one or both of the domains and preferred hospitals that do not meet benchmarks for cost or that use nonstandard reimbursement are placed in the Basic Benefits Tier.

It is important to consider the tier of both your provider and the facility where your provider has admitting privileges before you choose a preferred primary care provider or receive care. For example, if you require hospital care and your Enhanced Benefits Tier preferred primary care provider refers you to an Enhanced Benefits Tier preferred hospital, you would pay the lowest cost sharing for both your provider and hospital services. Or, if your Enhanced Benefits Tier preferred primary care provider refers you to a Basic Benefits Tier preferred hospital for care, you will pay the lowest copayments for preferred primary care provider services, but the highest copayments for hospital services, except in an emergency.

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com/findadoctor**
- Call our Physician Selection Service at **1-800-821-1388**

Note: In some out-of-state PPO service areas, different levels of preferred providers may not be available. In this case, your cost share will be the same as it would be for an Enhanced Benefits Tier preferred provider.

Out-of-Pocket Maximum.

Your out-of-pocket maximum is the most that you could pay during a plan year for deductible, copayments, and coinsurance for covered medical services.

Your out-of-pocket maximum is:

In-Network and Out-of-Network:
$2,000 per member (or **$4,000** per family)

Cost share amounts for pharmacy benefits are not included in this out-of-pocket maximum.

When You Choose Non-Preferred Providers.

After the plan-year deductible has been met, you pay **20 percent** coinsurance for most out-of-network covered services. Payments for out-of-network benefits are based on the Blue Cross Blue Shield of Massachusetts allowed charge as defined in your benefit description. You will be responsible for any difference between the allowed charge and the provider's actual billed charge (this is in addition to your deductible and/or your coinsurance).

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). You pay a **$150** copayment per visit for in-network or out-of-network emergency room services. This copayment is waived if you are admitted to the hospital or for an observation stay. There is no deductible for these services. Additionally, because you may not have a choice during an emergency, if you are admitted for an inpatient stay from the emergency room, you will be responsible for an Enhanced Benefits Tier copayment regardless of the tier of the hospital.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Pre-Service Approval for certain outpatient services, Concurrent Review and Discharge Planning, and Individual Case Management. Information concerning Utilization Review is detailed in your benefit description. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Plan-year deductible	None	$2,000 per member $4,000 per family
Plan-year out-of-pocket maximum	$2,000 per member/$4,000 per family for in-network and out-of-network services combined	
Covered Services		
Preventive Care Routine physical exams, including related tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life (age 1 to age 2) • Two visits for age 2 • One visit per calendar year from age 3 through age 18	Nothing	20% coinsurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing	20% coinsurance after deductible
Routine GYN exams, including related tests (one per calendar year)	Nothing	20% coinsurance after deductible
Routine vision exam (one every 24 months)	Nothing	20% coinsurance after deductible
Family planning services–office visits	Nothing	20% coinsurance after deductible
Hearing Benefits Routine hearing exams, including related tests	Nothing	20% coinsurance after deductible
Hearing aids (up to $5,000 per ear every 36 months)	All charges beyond the benefit maximum	20% coinsurance after deductible
Other Outpatient Care Emergency room visits	All Tiers: $150 per visit (waived if admitted or for observation stay)	$150 per visit, no deductible (waived if admitted or for observation stay)
Primary care provider visits at an office or health center	Enhanced Benefits Tier: $15 per visit Standard Benefits Tier: $25 per visit Basic Benefits Tier: $45 per visit	20% coinsurance after deductible
Specialists and other covered provider visits	$45 per visit	20% coinsurance after deductible
Chiropractor office visits	$45 per visit	20% coinsurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 100 visits per calendar year*)	$45 per visit	20% coinsurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$45 per visit	20% coinsurance after deductible
Mental health and substance abuse treatment	$15 per visit	20% coinsurance after deductible
Home health care and hospice services	Nothing	20% coinsurance after deductible
Oxygen and equipment for its administration	Nothing	20% coinsurance after deductible
Diagnostic X-rays, lab tests, and other tests, excluding MRIs, CT scans, PET scans, and nuclear cardiac imaging tests	Nothing	20% coinsurance after deductible
MRIs, CT scans, PET scans, and nuclear cardiac imaging tests • General hospital	(One copayment will apply to each category of test per date of service) Enhanced Benefits Tier: $75 per test Standard Benefits Tier: $150 per test Basic Benefits Tier: $250 per test	20% coinsurance after deductible
• Other covered provider	$75 per test	20% coinsurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	20% coinsurance**	40% coinsurance after deductible**
Prosthetic devices	Nothing	20% coinsurance after deductible
Outpatient Surgery (and related anesthesia) Office setting	Enhanced Benefits Tier: $15 per visit*** Standard Benefits Tier: $25 per visit*** Basic Benefits Tier: $45 per visit*** Other covered providers: $45 per visit	20% coinsurance after deductible
Surgical day care unit of a general hospital	Enhanced Benefits Tier: $150 per visit Standard Benefits Tier: $250 per visit Basic Benefits Tier: $500 per visit	20% coinsurance after deductible
Ambulatory surgical facility	$150 per admission	20% coinsurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

** In-network cost share waived for one breast pump per birth (20% coinsurance after deductible out-of-network)

*** Copayment waived for restorative dental services and orthodontic treatment or prosthetic management therapy for members under age 18 to treat conditions of cleft lip and cleft palate.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (and maternity care) General hospital care (as many days as medically necessary)	Enhanced Benefits Tier: $250 per admission Standard Benefits Tier: $500 per admission/ $300 per admission at selected hospitals† Basic Benefits Tier: $1,000 per admission	20% coinsurance after deductible
Chronic disease hospital, mental hospital or substance abuse facility care	$250 per admission	20% coinsurance after deductible
Rehabilitation hospital care (up to 60 days per calendar year)	Nothing	20% coinsurance after deductible
Skilled nursing facility care (up to 100 days per calendar year)	Nothing	20% coinsurance after deductible
Presciption Drug Benefits * At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	$15 for Tier 1** $30 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	$30 for Tier 1** $60 for Tier 2 $150 for Tier 3	Not covered

† The selected Standard Benefits Tier hospitals noted in this chart include Athol Memorial Hospital, Baystate Franklin Medical Center, Baystate Mary Lane Hospital, Falmouth Hospital, Martha's Vineyard Hospital, Nantucket Cottage Hospital, and North Adams Regional Hospital. The deductible does not apply for any covered services furnished by these hospitals.

* Cost share waived for certain orally administered anticancer drugs.

** Cost share waived for birth control.

Get the Most from Your Plan

Create an account at www.bluecrossma.com/membercentral or call us at **1-800-782-3675** to learn about discounts, savings, resources, and special programs like those listed below that are available to you.

Wellness Participation Program **Reimbursement for a membership at a health club or for fitness classes** This fitness program applies for fees paid to: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. (See your benefit description for details)	$150 per calendar year per policy
Reimbursement for participation in a qualified weight loss program This weight loss program applies for fees paid to: a qualified hospital-based weight loss program or a Blue Cross Blue Shield of Massachusetts designated weight loss program. (See your benefit description for details)	$150 per calendar year per policy
Blue Care Line℠—A 24-hour nurse line to answer your health care questions—call 1-888-247-BLUE (2583)	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com.**
Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.
Please Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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